



CT TEACHERS' RETIREMENT BOARD
165 CAPITOL AVENUE HARTFORD, CT 06106-1673
Toll-Free 1-800-504-1102 (959) 867-6333 Fax (860) 525-6018 www.ct.gov/trb

REVOCATION OF APPLICATION FOR A DISABILITY ALLOWANCE

This form is to be used by a member to revoke his/her Application for a Disability Allowance and must be received by the Connecticut Teachers' Retirement Board (CTRB) prior to the effective date of the disability allowance or postmarked prior to that date. A facsimile copy is acceptable, provided it is sent to CTRB prior to the effective date.

I _____, hereby notify CTRB of my intention to revoke my
(print name)
Application for a Disability Allowance that is to become effective as of _____
(print date)

I understand if I become disabled within three months of my revocation, I can resubmit my original application for disability and will not need to be reapproved by the Teachers' Retirement Board Medical Review Committee.

Additionally, I understand that if I become disabled after three months from my revocation I will need to reapply with updated physician's reports and be reapproved by the Teachers' Retirement Board Medical Review Committee.

Member's Name	Social Security Number
Street Address	Email Address
City, State, Zip	Home Phone
Member's Signature	Date Signed